

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN9011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/17/2012
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 140 TECHNOLOGY LANE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  An annual Licensure survey was completed on October 17, 2012, at Christian Care Center of Johnson City. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.		N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Administrator*

(X6) DATE

10/29/12

STATE FORM

5599

F4SD11

If continuation sheet 1 of 1

OCT 30 2012